CHAPTER IV: CLINICAL IMPLICATIONS OF THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

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OBJECTIVE

This chapter provides information on the partial hospitalization benefit, focusing particularly on the clarifications and the new recertification requirements contained in the OPPS Final Rule. Medical review implications of OPPS are also addressed.

PARTIAL HOSPITALIZATION

Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients who have profound and disabling mental health conditions with an individualized, comprehensive, coordinated, and multidisciplinary treatment program. The Medicare partial hospitalization benefit is designed to furnish services **in lieu of inpatient treatment**:

- For patients who exhibit disabling psychiatric/psychological symptoms
- For patients who experience an acute exacerbation of a severe and persistent mental disorder
- For patients who have been discharged from inpatient psychiatric care (in lieu of continued hospitalization)

The Medicare benefit categories for outpatient psychiatric services are partial hospitalization services or outpatient hospital psychiatric services. Medicare does not have a separate benefit category for substance abuse programs, intensive outpatient programs, and continuing day treatment programs. Because there is no separate benefit category for these programs, they must meet the Medicare requirements established for outpatient hospital psychiatric services or partial hospitalization programs in order to be covered.

Physician Certification and Recertification

Partial hospitalization
- **Certification**
- **Recertification**

A physician must initially certify a patient's need for partial hospitalization services and recertify the continued need for this intensive level of treatment. The OPPS Final Rule has amended 42 CFR §424.24(e) to establish physician recertification requirements for partial hospitalization services. Because partial hospitalization is the outpatient substitute for inpatient psychiatric care, the recertification time frames currently used for inpatient psychiatric care have been adopted in OPPS.

Initial Certification

The initial physician certification establishing the need for partial hospitalization must be received by the partial hospitalization program upon admission. Services provided to establish a patient's need for partial hospitalization services should continue to be billed to the carrier as professional services.

The current requirements for initial certification have not changed. Per 42 CFR 424.24(e)(1), the physician must certify:

- The individual would require inpatient psychiatric care if the partial hospitalization services were not provided.
- The services are or were furnished while the individual was under the care of a physician.
- The services were furnished under a written plan of treatment.

Recertification

The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment. The new recertification time frames are:

- The first recertification is required as of the 18th calendar day following admission to the program.
- Subsequent recertification is required no less frequently than every 30 days.

In addition, each recertification must specify:

- That the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the partial hospitalization program;
- The patient's response to the intensive, therapeutic interventions provided by the active treatment program which make up partial hospitalization services;

- Changes in functioning and status of the serious psychiatric symptoms that place the patient at risk of hospitalization; **and**

- Treatment plan and goals for coordination of services to facilitate discharge from the partial hospitalization program, such as community supports and less intensive treatment options.

Covered Partial Hospitalization Services

Partial hospitalization
- **Covered services**

The list of covered partial hospitalization services can be found in section 1861(ff) of the Social Security Act. The following services are identified as covered when reasonable and necessary for the diagnosis or active treatment of the individual's condition:

- Individual and group therapy with physicians, psychologists, or other mental health professionals to the extent authorized under State law

- Occupational therapy requiring the skills of a qualified occupational therapist

- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients

- Drugs and biologicals that cannot be self-administered and that are furnished for therapeutic purposes

- Individualized activity therapies that are not primarily recreational or diversionary

- Family counseling when the primary purpose is the treatment of the individual's condition

- Patient training and education to the extent that the training and education activities are closely and clearly related to individual's care and treatment

- Diagnostic services

Clarification of Covered Services

Partial hospitalization clarifications

The following information from the OPPS Final Rule is clarification of some of the covered services.

- Several services, such as patient education and training and activity therapy, may be provided by unlicensed but qualified staff who are specifically trained to work with the mentally ill. There is a new HCPCS code (G0172) for patient training and education services as a component of a partial hospitalization program. A HCPCS code (Q0082) for activity therapy as part of a partial hospitalization program has been in place for several years. The billing section of this manual contains instructions for the use of these codes.

- Other partial hospitalization services, for example, individual and group psychotherapy, family counseling, occupational therapy (OT), and diagnostic services, must be provided by licensed staff, authorized by the State to provide these services

The partial hospitalization per diem amount captures the provider's overhead costs, support staff, and the services of clinical social workers and occupational therapists. The data on which the per diem was based included the full range of services and the use of certain bundled professionals. Changes in services or increased use of unbundled practitioners will be monitored to evaluate and update the per diem rate. All the covered services and the multidisciplinary team who provide the services are important elements in creating the therapeutic milieu that distinguishes partial hospitalization programs from other outpatient mental health treatment.

Unbundled Professional Services

Partial hospitalization
- **Unbundled professional services**
- **Non-covered level of care**

According to 42 CFR 410.43(b), the following services are not paid as partial hospitalization services and are separately billable to the carrier:

- Physicians' services payable on a fee schedule basis
- Physician assistant services
- Clinical psychologist services

The OPPS FR has amended this list of services to include:

- Clinical nurse specialist services
- Nurse practitioner services

Non-Covered Level of Care

For partial hospitalization services to be covered, a physician is required to certify that the patient would otherwise require inpatient psychiatric care in the absence of the partial hospitalization services. The Medicare partial hospitalization benefit is not intended to provide support for the persistent and chronically mentally ill except when they are in an acute phase of their mental illness or to be a maintenance program.

Exclusions

Partial hospitalization providers should be aware that a new exclusion was added as part of the OPPS Final Rule:

- Hospital outpatient services furnished to skilled nursing facility (SNF) inpatients as part of the resident assessment or comprehensive care plan (and thus included under the SNF Prospective Payment System) that are furnished by the hospital "under arrangements" but billable only by the SNF, regardless of whether or not the patient is in a Part A SNF stay.

The SNF must reimburse the hospital or the CMHC for partial hospitalization services furnished to a resident when the SNF is receiving Medicare SNF PPS payment for the resident's inpatient stay.

MEDICAL REVIEW UNDER OPPS

Medical Review under OPPS

The goal of medical review is to identify inappropriate billing for services and to ensure that Medicare payment is not made for non-covered services. The implementation of OPPS has not changed Medicare coverage criteria. Intermediaries will review OPPS claims according to applicable HCFA regulations and local medical review policies.

Claims will continue to be subject to intermediary medical review edits. Both focused and random medical review will be conducted. The claim will pass through OCE edits and intermediary medical review edits before medical record requests are sent. This will assure that multiple medical record requests will not be issued for a single claim.

Intermediaries will conduct the following reviews:

- Complex medical review of all claims that are referred to medical review from the OCE until otherwise directed.
- Claims selected on a random basis.
- Focused medical review using guidelines specified in the Medicare Intermediary Manual (MIM), Pub. 13-3, Section 3920, *Medical Review Of Hospital Outpatient Claims*.

OCE Identified Reviews

OCE identified reviews
- **Non-covered service submitted for review (CC 20)**
- **Questionable covered service**
- **PHP edits**
- **Extensive mental health services provided on day of ECT or significant procedure**

With the implementation of OPPS, the OCE will identify certain claims to be suspended for medical review. Medical review will receive and review claims from the following OCE edits:

- Non-covered service submitted for review (condition code 20) (11)
- Questionable covered service (12)
- Partial hospitalization edits (30 – 34)
- Extensive mental health services provided on day of electroconvulsive therapy or significant procedure (36)

Random Review

Random review

The intermediary will select a limited sample of prepayment claims that have been approved for payment by the OCE (i.e., claims that have not been denied or suspended for medical review). Since OCE does not make coverage determinations these claims must be reviewed to ensure that the services billed were reasonable and necessary.

Focused Medical Review

Focused Medical Review
- **Edits**
- **High cost drugs and devices**
- **Vulnerabilities**

The intermediary will use focused medical review strategy for the majority of the medical review workload. The medical review department will:

- Establish edits that support prepayment or post-payment focused medical review based on the guidelines in the MIM, Pub. 13-3, Section 3939, *Focused Medical Review*, such as targeting:
  - Providers with significant error rates, and
  - Providers demonstrating questionable utilization patterns, such as consistent upcoding of HCPCS/modifier codes.
- Review high cost drugs and devices qualifying for transitional pass-through payments as identified in BBRA 1999 using review guidelines in MIM, Pub. 13-3, Section 3920.2B.
- Consider particular areas of vulnerability in data analysis and medical review activities per MIM, Pub. 13-3, Section 3920.2B. Examples of areas to be included for OPPS are:
  - Incorrect coding
  - Duplicate processing of OPPS services under carrier billing
  - Unrelated evaluation and management procedure codes (Modifier 25) on the same day with single/multiple surgeries
  - Billing of multiple same day visits on separate claims
  - Inappropriate use of partial hospitalization

Medical Review Implications of OPPS

While coverage has not changed, there are billing and payment changes related to OPPS that have medical review implications.

Medical review implications of OPPS
- **Transitional pass-throughs**
- **Incorrect coding**
- **Clinic and emergency room visits**

Transitional Pass-Throughs

Adjustments were made to OPPS as a result of the enactment of the BBRA 1999 in the form of transitional pass-throughs. Providers receive additional payment for certain identified services. The following designated services will be subject to focused medical review:

- Designated drugs and biologicals
- Designated medical devices

Incorrect Coding

Proper payment under OPPS is dependent on correct coding of services. APC groups were designed to limit opportunities for upcoding. However, due to the requirements of BBRA 1999, some clinically homogenous groups were further subdivided.

Intermediaries will consider incorrect HCPCS coding, and incorrect use of modifiers and condition code G0 in their medical review activities.

Clinic and Emergency Room Visits

Under OPPS, providers are required to bill medical visits to clinics and emergency rooms using a range of HCPCS codes that define the intensity of the visit. Since these codes were designed for physician billing, they do not accurately reflect facility resource utilization. HCFA is instructing hospitals to develop an internal system for mapping provided services or combination of services to the different levels of effort represented by the HCPCS codes. The HCPCS code billed by the hospital does not have to directly correlate to the physician-billed HCPCS code.

Each facility is held accountable for following its own system for assigning the different levels of HCPCS codes. Facilities are in compliance with these reporting requirements as long as:

- The services furnished are documented and medically necessary;
- The facility is following its own system; **and**
- The facility's system reasonably relates the intensity of hospital resources to the different levels of HCPCS codes.

Partial Hospitalization

Medical review implications of OPPS (cont'd)
- **Partial hospitalization**

Intermediaries will review the partial hospital claims according to currently existing guidelines contained in Program Memorandum A-99-39, issued in September 1999. Program Memorandum A-96-8 (reissue of PM A-95-8) regarding partial hospitalization requirements continues to be in effect. The partial hospitalization edits in the OCE will suspend claims for medical review based on the described set of parameters. (See the OCE section of this manual.)

The focus of the OCE partial hospitalization edits is to identify inappropriate billing of partial hospitalization services. These edits do not mean the claim will be automatically denied. Medical review will determine, upon examination of the patient's record, whether the partial hospitalization services are reasonable and necessary, whether the patient is eligible for the partial hospitalization benefit, and whether the program the patient is receiving qualifies as a partial hospitalization program.

It is only reasonable and necessary to pay the partial hospitalization per diem for short, less intensive days, if review of the medical record indicates that the patient belongs in a partial hospitalization program and is receiving an appropriate level of active treatment. For instance, if a patient had an appointment with the medical physician, it might be reasonable and necessary that the patient received less than three psychiatric services on that particular date of service. If electroconvulsive therapy or a surgical procedure and partial hospitalization services were rendered on the same date of service, documentation will be reviewed to determine if the partial hospitalization day is reasonable and necessary based on the patient's condition and ability to benefit from the services.

Movement to a per diem payment methodology for partial hospitalization services will necessitate changes in the medical review approach used by intermediaries. It will become necessary to ensure that all patients receive the level of service their individual condition requires. Some patients will require days of service that cost the provider more than the per diem payment amount. Other patients may require less intensive days of service during an acute episode of partial hospitalization care or as they transition out of the partial hospitalization program. Medical review guidance will be developed for intermediaries to obtain more consistency in medical review.

Medical Review Decisions

Payment determinations will be made based on whether the service:

- Is billed with the appropriate HCPCS/modifier code to describe the service furnished
- Is reasonable and necessary
- Is not excluded from coverage
- Is documented as furnished
- Meets all other requirements for coverage

Medical review decisions
- **Approve**
- **Change HCPCS code**
- **Partial denial**
- **Full denial**

Intermediaries will use the following guidelines to make determinations on OPPS claims:

- If the billed HCPCS/modifier code(s) meets all coverage requirements, the claim will be approved.

- If the service billed is covered, but is billed at an inappropriately higher HCPCS level, the claim will be adjusted. Medical review will select the HCPCS/modifier that appropriately reflects the service provided. The change in HCPCS/modifier will be reflected on the remittance advice.

- If some of the services furnished and billed were not reasonable and necessary, those services will be denied. If a primary procedure is determined to be non-covered and is denied by medical review, then the APC package including the associated ancillary or component services will also be denied.

- If all of the services billed on the claim were not reasonable and necessary, the claim will be denied.

- If some of the services furnished are excluded from coverage, the excluded services will be denied. If a primary procedure is determined to be non-covered and is denied by medical review, then the APC package including the associated ancillary or component services will also be denied.

- If all of the services billed on the claim are excluded from coverage, the claim will be denied.

- If the documentation received by medical review does not support that the billed HCPCS/modifier code(s) was furnished, the code(s) will be denied. Billing for services not documented is a fraud and abuse issue.

Claims will be passed through the OCE after a medical review determination is made so that the claim can have proper payment information assigned.

Denials

Denials
- **Full**
- **Partial**

Partial denials and full denials due to services not being considered reasonable and necessary are subject to appeal rights. Partial denial can be either:

- Denial of a specific services) as defined by the HCPCS/modifier codes)

- Reclassification of a HCPCS/modifier to a lower code